PURPOSE

To provide guidance for the establishment, assessment and collection of fees for services rendered to clients of the Community Services Board through its directly operated programs and contractual agencies and to assure that such fees are established in accordance with state statutes and regulations, in recognition of fiscal constraints, and in consideration of the needs of a client for services.

REIMBURSEMENT POLICY

1. It is the Community Services Board policy to serve all citizens in need of our services. It is our obligation to collect the cost of services from third party sources and from those who are able to pay.

2. Every effort shall be made to identify third party payers and clients shall be advised of this option. Failure by a client to utilize third party coverage, where applicable, shall result in assessment of full fee regardless of financial status.

3. No person shall be denied services due to inability to pay. Every effort shall be made to fairly set fees according to client's ability to pay.

4. Full fee shall be charged to all clients receiving services. Fee adjustments shall be determined by the Net Disposable Income as determined on the Financial Intake Form and based on this information clients are assigned an adjusted fee according to our fee scale. The Community Services shall absorb the difference between actual fee for services and amount determined as appropriate fee for clients.

5. Acceptance of less than full fee shall require the client or their guardian to undergo a financial intake, which will include providing proof of income. Proof of expenses may be required if they exceed allowable amounts.

6. In accordance with the Code of Virginia, 37.1-197 (7), we shall establish a reimbursement system to maximize the collection of fees from persons receiving services. Such a system shall take into account the need to provide services to persons regardless of their ability pay. Clinicians/Case Managers will play an active roll in collection procedures, when appropriate, by incorporating account delinquency situations into the client's treatment plan.

7. Reimbursement records will be kept on file for a minimum of 5 years.

8. The Financial Intake Questionnaire and multiple forms will be updated on a yearly basis. A minimum fee of $5.00 is charged. All fees are determined by information received through the financial intake process based on determination of their net disposable income. Payment for services rendered is expected at the time of each visit. Third party co-payments and deductible amounts will not be routinely waived. Clients will be responsible for payment of any and all "Non-Covered" services. Clients will be informed of the fee policy at the time of their financial intake.

9. All clients will be treated and charged in a like manner regardless of financial ability or third party coverage.

Approved_____ _____
Secretary Date

Adopted: January 1, 2001

REIMBURSEMENT PROCEDURES

I. INTRODUCTION

Clients are to be notified in advance of the information required for the financial intake.

A. Income verification

1. Current pay stubs
2. Copy of assistance checks
3. Copy of retirement checks
4. W-2 form
5. Current year tax return

B. When the appointment is scheduled, a search is to be conducted to determine if this is an established client and if there are any monies owed to the Community Services Board.

C. If the client is an established client owing money to the COMMUNITY SERVICES BOARD, he/she is to be informed of the amount of payment required prior to services being rendered. **EXCEPTION: THE CLIENT IS BEING SEEN FOR EMERGENCY SERVICES!**

II. FINANCIAL INTAKE

A. The client is informed of the reimbursement policy

1. The client is charged full fee for services rendered.
   The client may request a fee adjustment with appropriate income verification and every effort shall be made to fairly set fees according to client's ability to pay.
2. The client may use third party coverage to meet his/her obligation. However, if the client chooses not use his/her third party coverage they are not eligible for a fee adjustment.
3. Due to a federal mandate, there is not a routine waiver of co-insurance or deductible amount.
4. There is a minimum fee of $5.00.
5. Payment for services is expected at the time of each visit or according to the terms of their service agreement.
6. Client will be responsible for the payment of any "non-covered" services.
7. It is the client's responsibility to inform reimbursement staff immediately of any change in their financial status.

B. A Financial intake will be done on all clients requesting a fee adjustment.

C. Financial intakes will be performed in a private setting.

D. Financial intakes are performed at the time of the initial appointment.

E. A financial questionnaire must be completed.

F. Proof of income is required from the client or their guardian prior to any fee adjustment.

G. Proof of expenses exceeding the allowed amount will be required.

H. A signature from the client of responsible party is required certifying the information on the financial questionnaire is accurate.

III. DETERMINING CLIENT FEE

There are four approved fee categories for the:

(1) Full Fee Client

(2) Full Fee Payment Plan

(3) Insurance Client

(4) Financial Assistance

A. Full Fee Client/Full Fee Payment Plan
If the client does not request or qualify for a fee adjustment:

1. Complete and have the client or responsible party sign a "Financial Fee Agreement" form checking the appropriate box.

   a. Full Fee – Client agrees to pay full fee for services rendered at the time of the visit.

   b. Full Fee Payment Plan – Client agrees to pay full fee in monthly installments.

B. Fee Adjustment Client
Client requests and qualifies for an adjusted fee.

C. Insurance Client
Client has third party coverage to assist in payment of services and is not eligible for a fee adjustment.

1. Make a copy of the client's third party insurance card.
2. Have the client sign an "Authorization of Benefits" form.
3. Have the client sign a "Release of Information form".
4. Complete and have the client or responsible party sign a "Financial Fee Agreement" form checking the insurance box.

IV. FINANCIAL FOLDER

A. A client financial folder is created to include the following information/forms:

1. The client account number is automatically assigned by the computer.
2. Financial intake questionnaire.
3. Income verification.
4. Copy of third party insurance cards when applicable.
5. Signed "Financial Agreement" form.
6. Signed "Authorization of Benefits" form when applicable.
7. Signed "Release of Information" form when applicable.
8. Correspondence
9. Documentation of any telephone calls regarding account.

If client expresses hardship with his/her sliding fee, the "appeal" process may be performed. Upon completion and approval, the client must sign a revised Financial Agreement.

V. SERVICE TICKETS

A. After the initial financial intake has been completed or upon the client's arrival for further visits, a pre-numbered, two-part service ticket is created/completed for the client to include his/her name and account number.

B. One copy of the service ticket is detached and kept at the front desk.

C. The remaining copies are attached to the client's chart, given to the therapist and at the end of each session the therapist completes the service ticket. For those clients seen after hours, therapist is responsible for picking up tickets from the front desk before the close of the day and completing and returning them the following day.

D. Upon completion of the visit, the clinician is to verify all information printed on the ticket, correct any incorrect information and complete the service ticket with the following information:

1. Service rendered to the client.
2. The amount of time it took to render the service.
3. Clinician's signature.

E. The front desk staff will then do the following:

1. Match their copy of the service ticket with completed service ticket the client provides the.
2. Request payment from the client for services received.
3. If a check is received as payment it will be endorsed immediately.
4. Provide the client with a pre-numbered receipt for his/her payment.
5. All service tickets are then forwarded to the Reimbursement Office for batch entry/posting.

VI. RECEIPTS

A. Counter Receipts:

1. All checks will be endorsed immediately upon receipt and forwarded to the reimbursement office for processing and deposit.

2. Pre-numbered receipts will be issued for all payments made, regardless whether the client requests one or not.

3. Receipts received at satellite offices are proved and receipt numbers verified before forwarding to the Reimbursement Office with recap, copies of receipts, and signature of responsible party at that particular satellite office.

4. The A/P Fiscal Technician receives the receipts from the satellite offices, verifies receipt numbers and proves the receipts before forwarding to the Fiscal/Reimbursement Officer.

B. Receipts Received via Mail:

1. Payments received via mail are opened by the Administrative Assistant, or in his/her absence, by the Fiscal Technician.

2. All checks are endorsed immediately upon receipt.

3. All payments received via mail will be recorded in the Daily Mail Log Book.

C. The log and payments received via mail plus receipts received from the satellite offices are given to the Reimbursement Officer who will verify the deposit with the log and prepare the bank deposit.

1. Collections are reconciled with the receipt book when either of two criteria is met:
   (a) $100.00 has accumulated in the money box, or
   (b) One months receipts have accumulated.

2. Copies are made of all checks received.

3. Three copies are made of the bank deposit ticket. One copy is kept in the Reimbursement Office and attached to supporting documents i.e. copies of the checks, copies of the counter receipts and recap forms from the satellite offices. These documents are used for payment posting to client's accounts and then filed in the Monthly Fee Revenue Deposit File. The 3rd copy is filed in the Deposit Log Book and at the end of each month transferred to the Cash/Bank Statement Reconciliation Book.

4. The complete bank deposit is given to a staff member of the Fiscal Office or Administrative Assistant, who will then take the deposit to the bank.

5. The bank furnishes us with two copies of the Deposit Receipts. One copy is attached to the Reimbursement Office's copy and one is attached to the Fiscal Technician's copy.

VII. BILLING

Billing to ALL pay sources will be done monthly.

A. All services must be submitted for data entry by the 5th day of every month.

B. End-of-the month processing will be accomplished every month and will include the following:

1. Self pay monthly statements

2. Medicare claims

3. Medicaid claims

4. Blue Shield (UBS) claims

5. Commercial carrier claims

6. Substance Abuse contracts

7. Detailed aging report by pay source

C. Items 1 through 5 must be reviewed and mailed monthly.

VIII. COLLECTIONS

Collection procedures will be done monthly on all accounts. The detailed aging report by pay source will be used to accomplish the following tasks:

A. SELF PAY ACCOUNTS – ACTIVE CLIENTS

1. An account will be considered delinquent once it is 30 days old.

2. Once an account has been deemed delinquent, the reimbursement staff will issue the client a letter. A copy of the letter is filed in the client's chart to provide documentation of all collection activities.

3. Once the account becomes 60 days old, the reimbursement staff will notify the clinician/casemanager of the delinquency. The clinician/casemanager, during the next scheduled appointment, will discuss the issue and inform the client that if a payment is not received, services **could** be terminated.

4. A second letter is sent once the account becomes 60 days old. This letter explains that a previous letter was sent regarding the delinquent account and recommends payment or arrangement to be made within 30 days. A copy of the letter is filed in the client's chart.

5. If applicable, an appeal process can be initiated by the client or the clinician/casemanger if termination of services due to clinical reasons would be detrimental to the client's health or the client would pose a danger to society.

6. Once the account becomes 90 days old, a letter will be sent to the client requesting him/her to contact reimbursement to discuss his/her account. The client will also be informed that shall he/she decide not to contact the reimbursement staff, the account will be submitted for collection. A copy of the letter is filed in the client's chart.

7. Once the account becomes 120 days old, it will be deemed uncollectible, and services may be terminated due to the client's **REFUSAL** to pay (which is different from the client's **INABILITY** to pay).

8. The account is now reviewed by the Fiscal/Reimbursement Officer for final determination to transfer the balance from the active A/R and place into a Debt Set-off File. This is done so active A/R is not overstated.

9. The Fiscal/Reimbursement Officer will sign the 90-day letter to verify the transfer approval to the Debt Set Off File.

10. Should a client return for services at a later date, he/she would be required to pay the amount shown in the Debt Set Off File **prior** to services being rendered.
EXCEPTION: THE CLIENT REQUIRES EMERGENCY SERVICES!

B. SELF PAY ACCOUNT – INACTIVE ACCOUNTS

1. An account will be considered delinquent once it is 30 days old.

2. Once an account has been deemed delinquent, the reimbursement staff will issue the clients a letter. A copy of the letter is filed in the client's chart to provide documentation of all collection activities.

3. Once the account becomes 60 days old, a second letter is sent. This letter explains that a previous letter was sent regarding the delinquent account and recommends payment or arrangements to pay be made within 30 days. A copy of the letter is filed in the client's chart.

4. Once the account is 90 days old, a letter will be sent to the client requesting him/her to contact reimbursement to discuss his/her account. The client will also be informed that shall he/she decide not to contact the reimbursement staff, the account will be submitted for collection. A copy of the letter is filed in the client's chart.

5. Once the account becomes 120 days old it will be deemed un-collectible.

6. The account is now reviewed by the Fiscal/Reimbursement Officer for final determination to transfer the balance from the active A/R and place into a Debt Set Off File.

7. The Fiscal/Reimbursement Officer will sign the 90-day letter to verify the transfer approval to Debt Set Off File.

8. Should a client return for services at a later date, he/she will be required to pay the amount shown in the Debt Set Off File prior to services being rendered.
EXCEPTION: THE CLIENT REQUIRES EMERGENCY SERVICES!

C. THIRD PARTY INSURANCE ACCOUNTS – UNPAID ACCOUNTS

1. An unpaid claim is considered delinquent after 45 days of its submission.

2. A telephone call is made to the carrier to determine the status of the claim.

3. If the claim was never received, a copy of the original claim is submitted immediately.

4. If the claim has been pending for a reason, the reason is noted on the account and appropriate follow-up action will take place as required until the claim has been paid or denied.

D. THIRD PARTY INSURANCE ACCOUNTS – PAID CLAIMS

1. Those third party carriers that we are a participating provider for, i.e. Medicare, Medicaid, Blue Shield, etc., the difference between the CSB charge and allowed amount will be written off.

2. Any all applicable deductible and/or co-insurance amounts must be transferred to the client's self pay account.

3. For those third party carriers we do not have a signed contract with, i.e. Aetna, Jefferson Pilot, Connecticut General, etc., the balance from the CSB charge amount less the payment must be transferred to the client's self pay account.

E. THIRD PARTY INSURANCE ACCOUNTS – DENIED CLAIMS

1. Once a denial is received for a claim submitted, depending on the reason, the following action is taken:

   a. Denied Due To Non-Covered Service – the charge amount is transferred to the client's self pay account.

   b. Denied Due To Non-Qualified Provider – for those third party carriers that we do not have a contract with, i.e. Aetna, Jefferson Pilot, Connecticut General, etc., COMMUNITY SERVICES BOARD charges will be transferred to the client's self pay account.

   c. Denied Due To Service Limitations – the charge amount is transferred to the client's self pay account.

   d. Denied Due To No Coverage or Ineligibility – the charge amount is transferred to the client's self pay account.

   e. All other denials will require research for corrections and possible resubmission for payment.

IX. DEBT SET OFF FILE

A. Once an account is placed in the Debt Set-Off file, all billing of Client Monthly Statements will cease.

B. The Debt Set-Off file will contain the following information:

1. Client name

2. Client's account number

3. Client social security number
4. client or responsible party's address
5. Parent's name if client is a minor
6. Parent's social security number if the client is a minor
7. Amount owed
8. Payments if applicable

C. Following the monthly billing process, the Debt Set-Off client will be sent a letter of notification informing them that their account is being submitted to the Department of Taxation for a refund match if payment is not received within 30 days.

D. If no payment is received within 30 days, then a list is submitted to The Department of Taxation S.O.D.C. (Set-off Debt Collection).

E. S.O.C.D. (Set-off Debt Collection) policies are now followed.

F. Clients will remain in the bad debt/debt set-off file for five years or until payment via client of S.O.D.C. match is received, whichever occurs first.

G. Accounts are considered to be Bad Debts when all avenues of collection have been exhausted including D.S.O. and client services have been terminated at which time account will be transferred to the Bad Debt account and written off Accounts Receivable.

X. WRITE-OFF FROM DEBT SET-OFF FILE

CLIENT SELF PAY ACCOUNT

A. All accounts scheduled for write off, regardless of amount, have to be approved by the appropriate Program Director.

B. Reimbursement staff will compile a listing from the Debt Set-off File for those accounts that are five years old.

C. This list will be presented to the Reimbursement Officer for approval of the Write-offs.

XI. EMERGENCY SERVICES/CRISIS INTERVENTION BILLING

1. The Caseworker/E.S. Staff completes a Crisis Intervention Contact sheet at the time of the call or visit. This form is used to capture the service, time, and detailed demographic information needed for billing. A copy is forwarded to the Fiscal Technician for entry. The form is then filed in a completed batch.

2. A Crisis Intervention Brochure is given to the consumer at the time of the visit. The brochure provides an explanation of the service being rendered, who provided the services, and the referral source. The brochure also explains that there is a charge for the service. The perforated section of the brochure is completed by the E.S. Worker and signed by the consumer. This section is attached to the E.S. Contact Sheet, which is sent to the Fiscal Technician. The remaining piece of the brochure is given to the consumer for their information.

XII. SUBSTANCE ABUSE-DRUG & ALCOHOL FREE WORKPLACE COMPANIES

1. The SA Director establishes a contract with the company requesting the Testing and/or Assessment.

2. The SA Director sends a document stating the approved services and charges. The Reimbursement Technician assigns specific service codes, payer codes, and a client number for that company.

3. The individual tested are not “open clients”. They are they company’s employees.

4. The SA Therapist completes an Alcohol/Drug Free Workplace Service Ticket for each individual tested.

5. The ticket is forwarded to the Fiscal Technician for entry; the service ticket is filed in the company’s chart.

6. The companies will also be billed an annual Administrative Fee of $700.00. The fee is billed and due the month of the approved contract.

SUBSTANCE ABUSE – CONTRACTUAL SERVICES

1. The SA Director establishes a contract with the company requesting services for individuals.

2. The Reimbursement Technician assigns specific payer codes and service codes for the company or organization.

3. The individuals receiving services are “opened clients”.

4. The SA Therapist will complete a service ticket for the client. The therapist is to confirm the correct payer code is documented on the ticket.

5. The service ticket is forwarded to the Fiscal Technician for entry. The service ticket is filed in the completed batch.